ICF/MR TRANSFER FORM

To be used for transfers from ICF/MR to ICF/MR, ICF/MR to HCBS, or HCBS to ICF/MR
Not appropriate for transfers between waivers, or for transfers from ICF/MR to the Self-Determination Waiver

Mail to: TennCare, Division of Developmental Disability Services, 310 Great Circle Road, 2nd Floor East, Nashville, TN, 37243. It may be faxed to 615-741-9260, Attention: PAE Unit. Please attach a copy of page 1 of the current PAE.

A. This section to be completed by TennCare Date: _____

Reviewed by: _____

Control Number: _____

Transfer Criteria Met: _____

☐ YES Approved from _____ through _____

☐ NO Please resubmit PAE form in its entirety

Reason:

B. RECIPIENT INFORMATION

Name: _____ Sex: ____ DOB: _____
Last First Middle

Social Security Number: _____ Medicaid Number: _____

C. PAYMENT SOURCE UPON TRANSFER

☐ Medicaid

☐ Other

D. DESIGNATED CORRESPONDENT

Name: _____
Last First Middle

Address: _____

City, State, Zip: _____ Phone Number: ( )_____

E. TRANSFERRING FACILITY: _____ Provider Number: _____

Address: _____

City, State, Zip: _____

Contact Person: _____

Phone Number _____

Admit Date: _____ Projected Move Date: _____

Current Level of Care: ☐ICF/MR or ☐ HCBS _____

F. ADMITTING FACILITY: _____ Provider Number: _____

Address: _____

City, State, Zip: _____

Contact Person: _____ Phone Number: ( )_____

Transfer Request Date _____ Fax Number: _____

Level of Care Requested: ☐ HCBS _____ or ☐ ICF/MR

G. Plan of Care (for HCBS waiver-covered services, please include amount, frequency and duration; for ICF/MR, please include all habilitative services, including residential)

Physician's Signature _____